ANNUAL CHANGE ELECTION FORM

EMPLOYEE NAME
EMPLOYEE ADDRESS
EMPLOYEE ADDRESS
EMPLOYEE CITY STATE ZIP

Health Care and Benefits Division
PO Box 200130
Helena MT 59620-0130

INSTRUCTIONS & DEADLINE FOR ELECTIONS: Review your elections carefully by verifying the types and amounts of coverage, reviewing benefit offerings available online at www.benefits.mt.gov, and making any necessary changes to the appropriate sections of this form by **within 31 days of hire**. The form may be sent through the U.S. Postal Service, through State of Montana (deadhead) mail service, or dropped off at 100 N Park, Suite 320 in Helena. Giving your form to your employer or payroll personnel does not constitute filing with the Health Care and Benefits Division.

CURRENT BENEFITS	**2016 BENEFIT ELECTION**
Medical	☐
Dental	☐
Vision Hardware - Re-enrollment Required	☐
Basic Life	☐
Dependent Life	☐
Employee Supplemental	☐
Spouse Supplemental	☐
AD&D	☐
Pre-Tax Plan	☐
Long Term Disability	☐
State Share	☐
TOTAL OUT-OF-POCKET BENEFIT PAYMENTS	

I. PRE-TAX PLAN - Your current election will automatically continue, unless you indicate otherwise below.

❑ Continue with current coverage

❑ Yes, I want my deductions withheld on a pre-tax basis ❑ No, I want my deductions withheld on an after-tax basis

Add or delete dependents (s): Verify that the information below is accurate. Make changes where necessary. Please remember, employees are required to participate in medical, dental, and basic life. During this annual change period, dependent children under 26 years of age and a spouse or domestic partner may be added. To delete/add a dependent from coverage, check the Delete/Add box next to each dependent's name and **circle** the type of coverage to be deleted/added.

Delete	Add	Coverage**	Name	Birth date	Rel*	Tax Status	SSN
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						

*Rel. = Relationship • E = Employee • SP = Spouse • D = Daughter • S = Son • X = Disabled

**Coverage • M=Medical • D=Dental • V=Vision

II. MEDICAL

❑ Elect Joint Core* (only for married spouses/domestic partners who are both employed by the State and have covered dependents. Your spouse/domestic partner must also submit their Individual Benefit Statement to enroll)
*Employee's Joint Core Partner & SSN _____

❑ Cancel Joint Core (Spouse must also submit their Individual Benefit Statement to cancel.)

III. DENTAL - Basic dental will not be available in 2016. See your Annual Change book for more details.

IV. VISION HARDWARE COVERAGE - Choose the appropriate box below. You or your dependent must be enrolled in medical to be eligible for vision hardware. Please note if you choose to participate in the vision hardware plan, **all** dependents enrolled in the medical plan will be enrolled.

❑ Yes, I want to enroll ❑ No, I do NOT want to enroll

V. LIFE INSURANCE - Salary for calculating minimum and maximum coverage $

When selecting your life coverage, please keep in mind that you MAY receive a salary increase in November that could increase the minimum amount of life coverage you are required to elect. Your spouse could get up to $10,000 in spouse life without evidence of in-insurability. HCBD will automatically make this adjustment. Employees can also increase existing coverage by $10,000 without evidence of insurability.

❑ Continue with current coverage

- ❑ **Employee Supplemental Life - $5,000 increments up to $500,000** (*See your annual change booklet for Coverage options)*
  ❑ Cancel ❑ Add or Change - New total amount:_____
- ❑ **AD & D with dependents - $25,000 increments up to $500,000**
  ❑ Cancel ❑ Add or Change - New total amount:_____
- ❑ **AD & D without dependents - $25,000 increments up to $500,000**
  ❑ Cancel ❑ Add or Change - New total amount:_____
- ❑ **Dependent Life**
  ❑ Cancel
- ❑ **Spouse Supplemental Life- $5,000 increments up to 100% of Plan C** (*Applications will be sent if new election exceeds $10,000)*
  ❑ Cancel ❑ Add or Change - New total amount:_____

VI. LONG TERM DISABILITY INSURANCE - Choose the appropriate box below.

❑ Continue with current coverage ❑ Yes, I want to enroll ❑ Cancel

VII. FLEXIBLE SPENDING ACCOUNTS (FSA) - Enrollment is NOT automatic! You must select an account and indicate an amount to enroll in an FSA. If you elect an FSA, you must also participate in the Pre-Tax Plan. Calculate the yearly FSA amount keeping in mind the yearly amount must be divisible evenly by 24. Your election will be adjusted to an even amount if necessary.

❑ Medical Expense FSA _____**YEARLY AMT** ($120 min/$2499.84 yearly max)

❑ Dependent/Child Care FSA _____ **YEARLY AMT** ($120 min/$4999.92 household yearly max)

IX. READ AND SIGN

<u>NOTICE OF CHANGE IN PROCESS:</u> You will no longer receive a confirmation statement. The elections that you make on this form are final and will be binding for the upcoming plan year unless you or a dependent have a qualifying event as described in the Summary Plan Document.

I request the election changes indicated above and authorize the associated payroll deduction. I understand that if I am adding a new spouse or domestic partner to my benefits or my spouse or domestic partner's tax status has changed, I must complete a Declaration of Tax Status available on www.benefits.mt.gov. Failure to return the Declaration of Tax Status form and any required documentation will result in my dependent being defaulted to a non-qualified tax status. I understand that other information may be required for the change that I have requested, and I am responsible for completing and returning any forms sent to me by the Health Care and Benefits Division before processing of my requested change will continue. **I understand that there will not be a confirmation process this year, and that the changes indicated above are final.**

Signature: _____Date:_____